

ALLERGY MEDICAL ACTION PLAN (as of 7 Aug 08)

(to be completed by Health Care Provider)

Child's Name	Date of Birth	CYS Program/Activity
Sponsor Name		
Health Care Provider	Health Care Provider Phone	

Allergies (please list)

Mild Symptoms

Several hives, itchy skin, swelling at the site of an insect sting, other: _____

Emergency or Life Threatening Symptoms:

Mouth/Throat: Itching and swelling of lips, tongue, mouth, throat, throat tightness, difficulty swallowing, hoarseness or cough.

Skin: hives spreading over body, itchy rash; swelling

Gut: Nausea, abdominal cramps, vomiting, diarrhea

Lung: Shortness of breath, coughing, wheezing

Heart: pulse is hard to detect, "passing out", extreme paleness or gray colored skin

Treatment Protocol (List in order of precedence)

- ☐ Oral Benadryl only, dosage: _____; call parent. When to give: _____
 - ☐ Give EpiPen; call 911, then parent. When to give: _____
 - ☐ Other- _____
- When to give: _____

Emergency Response

- Stay with child
- Contact parents/guardian
- Seek emergency medical care if the child has _____

**IF THIS HAPPENS
GET EMERGENCY HELP
NOW!
CALL 911**

- Hard time breathing with:
 - Chest and neck pulled in with breathing
 - Child is hunched over
 - Child is struggling to breathe
- Trouble walking or talking
- Stops playing and can't start activity again
- Lips and fingernails are gray or blue

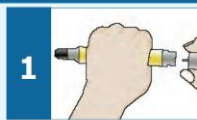
Follow Up

This Allergy Medical Action Plan will be updated/revised whenever medications or child's health status changes, and whenever child is transitioned to a new program. If there are no changes, the Allergy Medical Action Plan will be updated at least every 12 months.

Date of Registration Renewal

YYYYDDMM: _____

How to give EpiPen® or EpiPen® Jr



1 Form fist around EpiPen® and pull off grey cap.



2 Place black end against outer mid-thigh. Support the child.



3 Push down HARD until a click is heard or felt and hold in place for 10 seconds.



4 Remove EpiPen® and be careful not to touch the needle. Massage the injection site for 10 seconds.

ALLERGY MEDICAL ACTION PLAN ADDITIONAL CONSIDERATIONS

(to be completed by Health Care Provider)

Medications for Allergy

For children requiring rescue medication, the medication is required to be at program site at all times while child is in care. For youth who self-medicate and carry their own medications, medication must be with the youth at all times. The options of storing "back up" rescue medications at program is available.

Field Trip Procedures

Rescue medications should accompany child during any off-site activities.

- The child should remain with staff or parent/guardian during the entire field trip. ☐ Yes ☐ No
- Staff members on trip must be trained regarding rescue medication use and this health care plan. This plan must accompany the child on the field trip.
- Other (specify) _____

Self-Medication for School Age/Youth

☐ **YES.** Youth can self-medicate. I have instructed _____ in the proper way to use his/her medication. It is my professional opinion that he/she SHOULD be allowed to carry and self administer his/her medication. Youth has been instructed not to share medications and should youth violate these restrictions the privilege of self medicating will be revoked and the youth's parents notified. Youth are required to notify staff when carrying medication.

OR

☐ **NO.** It is my professional opinion that _____ SHOULD NOT carry or self administer his/her medication.

Bus Transportation should be alerted to child's condition.

- This child carries rescue medications on the bus. ☐ Yes ☐ No
- Rescue medications can be found in: ☐ Backpack ☐ Waistpack ☐ On Person ☐ Other _____
- Child will sit at the front of the bus. ☐ Yes ☐ No
- Other (specify): _____

Sports Events/Instructional Programs

Parents are responsible for having rescue medication on hand and administering it when necessary when the child is participating in any CYS sports/instructional activity. Volunteer coaches and instructors do not administer medications.

Parental Permission/Consent

Parent's signature gives permission for child/youth personnel who have been trained in medication administration by the APHN to administer prescribed medicine and to contact emergency medical services if necessary. I also understand my child must have required medication with him/her at all times when in attendance at CYS programs.

Youth Statement of Understanding

I have been instructed on the proper way to use my medication. I understand that I may not share medications and should I violate these restrictions, my privileges may be restricted or revoked, my parents will be notified and further disciplinary action may be taken. I am also required to notify staff when carrying or taking my medication.

I agree with the plan outlined above

Printed Name of Parent/Guardian	Parent Signature	Date (YYYYMMDD)
Printed Name of Youth	Youth Signature	Date (YYYYMMDD)
Stamp of Health Care Professional	Health Care Professional Signature	Date (YYYYMMDD)
Printed Name of Army Public Health Nurse	Army Public Health Nurse Signature	Date (YYYYMMDD)